DALLAS COUNTY COMMUNITY SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

DALLAS COUNTY COMMUNITY SERVICES: 902 Court Street, Suite 1, Adel, IA 50003

CONSUMER: STATE ID #: DOB:

CONSUMER ADDRESS:

I, the undersigned, hereby authorize **Dallas County Community Services** staff to release and/or obtain verbal, electronic, or written information indicated below, regarding the above named consumer, with:

_____

Name of Person or Agency

_____

Complete Mailing Address

The information being released will be used for the following purpose:

- ☐ Planning and implementation of my Individual Comprehensive Plan
- ☐ Coordination of services
- ☐ Monitoring of services
- ☐ Referral for new services
- ☐ Other (specify)_____

INFORMATION TO BE RELEASED FROM THE CASE MANAGEMENT PROGRAM:

Yes	No	
☐	☐	SOCIAL HISTORY
☐	☐	PROGRESS SUMMARY REPORT
☐	☐	INDIVIDUAL COMPREHENSIVE PLAN
☐	☐	ANNUAL REVIEW
☐	☐	DISCHARGE SUMMARY
☐	☐	RE-RELEASE OF 3RD PARTY INFO (specify)_____
☐	☐	OTHER (specify)_____

INFORMATION TO BE OBTAINED FROM THE AGENCY INDICATED ABOVE:

Yes	No	
☐	☐	SOCIAL HISTORY
☐	☐	EDUCATIONAL/VOCATIONAL PLANS
☐	☐	PROGRESS SUMMARY
☐	☐	PSYCHOLOGICAL EVALUATIONS/REPORTS
☐	☐	PSYCHIATRICASSESSMENT/REPORTS
☐	☐	MEDICAL HISTORY
☐	☐	TREATMENT PLAN
☐	☐	DISCHARGE SUMMARY
☐	☐	RE-RELEASE OF 3RD PARTY INFO (specify: _____
☐	☐	OTHER (specify)_____

No express revocation shall be needed to terminate my consent, I understand that this consent is voluntary and I may revoke this consent at any time by sending a written notice to the (program) Case Management program. I understand that any information released prior to the revocation may be used for the purposes listed above, and does not constitute a breach of my rights to confidentiality. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and once the information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information by contacting the recipient named, or (program) Case Management.

I understand that I can refuse to sign this authorization, but failure to provide access to information necessary for the funding and implementation of services may be a basis for denial of services.

This authorization shall expire on: _____(not to exceed 12 calendar months from date of signature, unless revoked or as specified – list specific event, date or condition:_____).

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OF FEDERAL LAW. I specifically authorize the release of data and information relating to Mental Health:

Signature of Consumer or Legal Guardian: _____

Date

_____

Relationship if Not The Consumer

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OF FEDERAL LAW

(In order for this information to be released, you must sign here and above)

I specifically authorize the release of data and information relating to (check all that apply):

☐ **Substance Abuse** (must be signed by the consumer) ☐ **HIV-Related Information**

_____ _____

Consumer Signature Date Guardian Signature Date